(For State Use Only)

OHIO MEDICAID PROVIDER AGREEMENT

(For all providers except Long-Term Care Facilities)

This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service.

2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.

3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.

4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.

5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.

6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;

7. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-1-173 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.

8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title XX beneficiaries.

9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.

10. Provide to ODJFS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".

11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d).

This provider agreement may be canceled by either party upon 30 days written notice prior to termination date except in the case of health maintenance organizations (HMOs) who must notify the Department in writing at least 90 days prior to the date of cancellation.

I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

Individual Practitioner Name and Title (please print): Tammie Proffitt Provider

Individual Practitioner Signature: Tammie Proffitt Date: 06/15/2006 (mm/dd/yyyy)

ATTACH ALL COPIES OF LICENSURE, CERTIFICATION, REGISTRATION, ETC., AS REQUIRED FOR YOUR PROVIDER TYPE
APPLICATIONS SUBMITTED WITHOUT THE REQUIRED ATTACHMENTS WILL BE CONSIDERED INCOMPLETE AND RETURNED TO THE APPLICANT

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Signature of Authorized Agent: _____ Date: __/__/____ (mm/dd/yyyy)